

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-033785

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8819

FILED SEP 6 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR  
TOWN

St. Louis

Length of stay in -1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY St. Louis

c. CITY  
OR  
TOWN

Clayton

Inside Limits  
Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR  
INSTITUTION

Jewish Hospital

Inside Limits

Yes ☒ No ☐d. STREET  
ADDRESS

6325 Southwood

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED  
(Type or print)First  
SOL

Middle

Last  
KAISER4. DATE  
OF  
DEATHMonth Day Year  
August 30, 19635. SEX  
Male6. COLOR OR RACE  
White7. Married ☒ Never Married ☐  
Widowed ☐ Divorced ☐8. DATE OF BIRTH  
3/10/929. AGE (last birthday)  
71IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Executive

10b. KIND OF BUSINESS OR INDUSTRY

Loan Company

11. BIRTHPLACE (City and state or country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Louis Kaiser

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

Rae Kosky Kaiser

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of)

Unk.

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. S. Kaiser-6325 Southwood

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic Heart Disease

INTERVAL BETWEEN  
ONSET AND DEATH

Phro

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

DUE TO (b)

DUE TO (c)

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal  
disease condition given in PART I (a)

Left Hemiplegia

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒20a. ACCIDENT ☐SUICIDE ☐HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF  
INJURYHour  
a.m.  
p.m.

Month, Day, Year

20d. INJURY OCCURRED  
WHILE AT WORK ☐  
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,  
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

2/23/43 to 8/30/63

and last saw him live on 8/30/63

Death occurred at

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Mavis Cleef Wad

22b. ADDRESS

3720 Washington Ave

22c. DATE SIGNED

8/31/63

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Removal

23b. DATE

9/1/63

23c. NAME OF CEMETERY OR CREMATORY

Chesed Shel Emeth Cem. St. Louis County, Mo.

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

Herman Rindskopf, Inc. 5216 Delmar

25. DATE RECD. BY LOCAL REG.

SEP 3 1963

26. REGISTRAR'S SIGNATURE

Loal Smith, M.D.

5705  
Bra



**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John Ketter*

Licensed Embalmer No. 3880

P. O. Address \_\_\_\_\_

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.